DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **01-009**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FILE COPY

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B

Pages 1, 1a, 9, and 9a & 1b & 9b (RH)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B

Pages 1 and 9

10. SUBJECT OF AMENDMENT:

Payment Rates and Methodologies for Clinic Services and Federally Qualified Health Care Centers

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
by Dunbar for

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED: 3/30/01

16. RETURN TO:
Department of Social and Health Services
Medical Assistance Administration
623 8th St SE MS: 45500
Olympia, WA 98504-5500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 20 2001

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Teresa L. Trumble

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID

23. REMARKS:

"FAXED" 3/30 (DATE) Olympia

PAI changes were authorized by the State on 6/13/01.

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Policy and methods used in establishing payment rates for each of the other types of care or service listed in Section 1905(a) of the Act that is included in the program under the Plan.

I. General

A. The state agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus cost of materials.
B. The state agency has access to data identifying the maximum charges allowed; such data will be made available to the Secretary of Health, Education, and Welfare upon request.
C. Fee structures will be established which are designed to enlist participation of a sufficient number of providers and services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.
D. Participation in the program will be limited to the providers of services who accept, as payment in full, the amounts paid in accordance with the fee structure.
E. State payment will not exceed upper limits as described in regulations found in 42 CFR 447.250 through 447.371. Any increase in a payment structure that applies to individual practitioner services will be documented in accordance with the requirements of 42.CFR 447.203.

II. Clinic Services

A. Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Payment will not exceed the prevailing charges in the locality for comparable services under comparable circumstances. Specialized clinics are reimbursed only for services the clinic is approved to provide.

B. Rural Health Clinics - Effective January 1, 2001, the payment methodology for Rural Health Clinics (RHCs) will conform to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

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B. Rural Health Clinics (continued)

Within BIPA 2000, all RHCs are reimbursed on a prospective payment system (PPS) with respect to services furnished on or after January 1, 2001 and each succeeding year.

Using the PPS methodology, the payment is set prospectively using an average of the clinic's total reasonable costs for the clinic's fiscal years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001 to establish an encounter rate. Beginning in the clinic's fiscal year 2002 and any fiscal year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the clinic's scope of services.

BIPA 2000 allows for payment to an RHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the clinic that is at least equal to the PPS payment rate. Since the State's current methodology results in a payment that is at least equal to the PPS payment rate, the State will continue to pay RHCs using its current methodology as an alternative to the PPS. Further, this alternative methodology will be agreed to by the State and the RHC, and documentation of each clinic's agreement will be kept on file by the RHC Program Manager. If an individual RHC does not agree to be reimbursed under this alternative methodology, the RHC will be paid under the BIPA PPS methodology.

Under the State's current methodology, both provider-based and free-standing RHCs will be reimbursed on an encounter rate basis for primary care services, as established for the clinic by the Medicare carrier using the clinic's audited Medicare Cost Report. The State will update the encounter rate annually, when notified by the Medicare carrier of a rate change. The State will annually recalculate the clinic's reasonable encounter rate for fiscal year 1999 and 2000 plus the Medicare Economic Index for primary care services to insure that the alternative rate is at least

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B. Rural Health Clinics (continued)

equal or greater than the PPS rate. Reimbursement for services other than rural health care primary care services will be reimbursed at a fee-for-service rate established by the State. Medicaid-Medicare patients will be reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

Rural Health Clinics receiving their initial designation after January 1, 2001 will be paid the encounter rate established by the Medicare carrier as reported to the State. The new clinic's rate will be rebased annually using the same methods as above.

For clients enrolled with a managed-care contractor, the State will pay the clinic a supplemental payment on a per member per month basis, in addition to the amount paid by the managed-care contractor. This will insure the clinic is receiving payments at least equal to that amount the RHC would receive under the BIPA PPS methodology.

C. Clinic services in comprehensive outpatient rehabilitation facilities will be paid the lesser of Medicare's upper limits or the department's fee schedule.

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XVI. Federally Qualified Health Care Centers

Effective January 1, 2001, the payment methodology for Federally Qualified Health Centers (FQHCs) will conform to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Within BIPA 2000, all FQHCs are reimbursed on a prospective payment system (PPS) with respect to services furnished on or after January 1, 2001 and each succeeding year.

Using the PPS methodology, the payment is set prospectively using the average of the center's total reasonable costs for the center's fiscal years 1999 and 2000, and adjusted for any increase or decrease in the scope of services furnished during the center's fiscal year 2001 to establish an encounter rate. Beginning in the center's fiscal year 2002 and any fiscal year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the center's scope of services.

BIPA 2000 allows for payment to an FQHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the center that is at least equal to the PPS payment rate. Since the State's current methodology results in a payment that is at least equal to the PPS payment rate, the State will continue to pay FQHCs using its current methodology as an alternative to the PPS. Further, this alternative methodology will be agreed to by the State and the FQHC, and documentation of each center's agreement will be kept on file by the FQHC Program Manager. If an individual FQHC does not agree to be reimbursed under this alternative methodology, the FQHC will be paid under the BIPA PPS methodology.

Under the State's current methodology, an FQHC will be reimbursed for services provided to Medicaid clients on an encounter rate basis for services provided. The encounter rate will be based on 100 percent of the center's reasonable and necessary costs as reported by the center on its cost report for the respective fiscal year. Once an audit of the center's reported costs is performed by MAA, an audited encounter rate will be established for each fiscal year period, and a

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XVII. Federally Qualified Health Care Centers (Continued)

settlement process will be done substituting the audited rate for the submitted rate. Any resulting underpayment or overpayment to the FQHC will be paid out or recouped. The State will update the encounter rate annually, using the center's submitted cost report from its most recent closed fiscal year. The State will annually recalculate the center's reasonable encounter rate for fiscal year 1999 and 2000 plus the Medicare Economic Index for primary care services to insure that the alternative rate is at least equal or greater than the PPS rate. Medicaid-Medicare patients will be reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

FQHCs receiving their initial designation after January 1, 2001 will be paid the encounter rate established by its provisional cost report. After the close of its fiscal year, its encounter rate will be adjusted using its submitted cost report. A settlement process will then be done, as above, once an audit of the center's cost report has been completed. The new center's rate will be rebased annually using the same methods as above.

For clients enrolled with a managed-care contractor, the State will pay the center a supplemental payment on a per member per month basis, in addition to the amount paid by the managed-care contractor. This will insure the center is receiving payments at least equal to that amount the FQHC would receive under the BIPA PPS methodology.

XVII Medical Services Furnished by a School District
Reimbursement to school districts for medical services provided will be at the usual and customary charges up to a maximum established by the state.

XVIII Mental Health Services
Each community mental health provider participating in the Medicaid program is required to submit a cost report. These cost reports are aggregated, subjected to statistical tests, and the resulting information is used to determine a cost-based

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XVIII Mental Health Services (Continued)

rate for each provider. These rates are arrayed, from lowest to highest, and statewide maximum rates are set using the 55th Percentile of provider reported costs. Providers are required to bill their usual and customary charge (UCC) and they are paid at the UCC or the statewide maximum rate, whichever is lower. This process ensures that 100 percent of cost is covered for the most efficient 55 percent of the providers and provides an incentive for higher cost providers to lower their cost of providing service.